KNOX COUNTY COMMUNITY Health Center
KNOX PUBLIC HEALTH

KNOX COUNTY HEALTH CENTER

11660 Upper Gilchrist Road, Mount Vernon, OH 43050

MEDICAL RECORDS RELEASE FORM

NAME OF PATIENT_____ DOB_____

ADDRESS_____

CITY_____STATE_____ZIP_____

RELEASE OF RECORDS FROM:	RELEASE OF RECORDS TO:
_____	_____
NAME OF PHYSICIAN	NAME OF PHYSICIAN
_____	_____
NAME OF HEALTH CARE FACILITY	NAME OF HEALTH CARE FACILITY
_____	_____
ADDRESS	ADDRESS
_____	_____
CITY, STATE, ZIP	CITY, STATE, ZIP

INFORMATION TO BE RELEASED:

☐ ALL CLINIC RECORDS	☐ LAB REPORTS
☐ X-RAY REPORTS	☐ ELECTROCARDIOGRAMS
☐ IMMUNIZATION RECORDS	☐ OTHER (SPECIFY) _____

List other facilities records to be included when releasing for the purpose of continuing medical care: _____
_____.

Purpose or need for disclosure (check applicable categories)

☐ Further medical care	☐ Payment of insurance claim	☐ Legal investigation
☐ Application for insurance	☐ Vocational rehabilitation evaluation	☐ Personal
☐ Disability determination		☐ Other

I understand that this authorization shall be valid for one (1) year unless revoked through written notice to the Knox County Health Department Clinic.

I AUTHORIZE RELEASE OF MY MEDICAL RECORDS IN ACCORDANCE WITH THE SPECIFICATIONS LISTED ABOVE. I UNDERSTAND WRITTEN NOTICE IS NECESSARY TO CANCEL THIS REQUEST.

SIGNATURE OF PATIENT_____DATE_____

If signed by a legal representative, please provide your relationship to the patient (i.e. guardian, power of attorney, executor) **and any required documentation to support this relationship.**

Signature of witness _____Date _____